An Antibiotic-induced Staphylococcal Enterocolitis

SIR,—I read with great interest Mr. B. J. Fowler's article, "Post-operative Staphylococcal Enterocolitis during Antibiotic Therapy" (*Journal*, May 28, p. 1313). I would like to report a further example of this condition.

On May 16 a woman aged 37 was admitted with a perforated gastric ulcer, which was closed surgically. As the operative findings indicated that the perforation was somewhere over 24 hours, terramycin 250 mg. six-hourly was given prophylactically; the first 500 mg. were given intravenously. By the end of the second post-operative day all signs of paralytic ileus had disappeared, but because of a slight evening temperature (100° F. (37.8° C.)) the terramycin was continued. On the third post-operative day the bowels opened normally, but the stool was rather loose. On the fourth day the bowels acted 8 times in 24 hours. The fluid stool was yellowish, and contained flecks of mucus. There was no nausea or vomiting, and the only abnormal finding was a slightly tender mass in the pelvis, insufficient to cause the symptoms. The terramycin was blamed and, despite a rising temperature, now 101° F. (38.3° C.), was discontinued.

On the fifth day the patient collapsed with, apparently, a complete circulatory failure. Over the past 12 hours she had vomited four times, and had had 20 very fluid motions. There were no signs of cardiac disease or pulmonary complications. The abdomen was soft, not distended, slightly tender on the right side, and with loud and almost continuous bowel sounds. The small, tender pelvic mass had not increased in size. In consultation with Dr. W. Brinton, peripheral circulatory failure was diagnosed, believed to be due to pus in the pelvis. Blood investigations showed Hb 100%, P.C.V. 49, W.B.C. 9,400; the differential count was within normal limits. The serum sodium was 148, serum potassium 5.3, and serum chloride 91 mEq/litre, and the blood urea 70 mg./100 ml. Further surgery was considered unjustifiable and unwarranted. A Ryle's tube was replaced, and the stomach aspirated regularly. Fluid was replaced by intravenous drip, and oral intake limited to 1,000 ml. a day, as larger quantities seemed to increase the diarrhoea and cause nausea. 15 mg. of methylamphetamine hydrochloride was placed in each of the first two bottles of the drip; 50 mg. of cortisone was given intramuscularly, and continued at 25 mg. six-hourly. Because of this and the fact that the condition was thought to be primarily due to sepsis, terramycin 250 mg. six-hourly was recommenced. On the sixth post-operative day the clinical picture was similar, but the profuse bowel actions were now, like the stomach aspiration, blood-stained. The urinary output for the past 24 hours was 1,260 ml. against an intake of 5,000 ml. Treatment was unaltered, except for the quantity and type of intravenous fluid given.

Until the eleventh post-operative day the condition remained unaltered. The bowel actions at times were almost continuous. The fluid stool that had shown a heavy melaena was now a dark green colour. The urinary output had dropped to between 300 ml. and 900 ml. a day, and maintaining fluid and electrolyte balance was a problem. In five days she had had 51 pints (29 litres) of fluid intravenously, consisting of normal saline, potassium chloride, glucose saline, "dextraven," molar lactate, plasma, and blood. The Ryle's tube had been removed because of a sore throat, and the nausea and vomiting had ceased. The blood pressure was maintained at 110/70, but on the ninth post-operative day the blood electrolytes began to show abnormal changes. The blood urea rose to 350 mg./100 ml., the serum sodium fell to 123, the serum potassium to 4.4, the serum chloride to 81, and the serum bicarbonate to 21 mEq/litre. The clinical picture remained almost identical to that of the fifth post-operative day, except that there was no dehydration. As the physical signs did not suggest a further intraperitoneal catastrophe, or that the diarrhoea was entirely secondary to a pelvic abscess, the original treatment was continued, substituting penicillin for terramycin. "Pamine" bromide (methscopolamine bromide) was given to diminish bowel actions, as standard procedures had failed to produce any result. In the next 48 hours the diarrhoea lessened to five fluid stools in 24 hours. Cultures from the throat, rectum, and faeces had grown a profuse growth of coagulase-positive staphylococcus resistant to penicillin, streptomycin, and terramycin, but sensitive to chloramphenicol. The latter was therefore given orally, 500 mg. six-hourly, with unlimited fluids and a regulated diet by mouth. The intravenous drip was discontinued. During the 14th and 15th post-operative days remarkable progress was made, and by the 16th day there was no incontinence and the bowel actions, four a day, were more solid. Urinary output had risen to 1,600 ml. against an oral intake of 2,800 ml. The blood urea had fallen to 36 mg.%, and the serum potassium to 3 mEq/litre, while the serum sodium had risen to 135, the serum chloride to 86, and the serum bicarbonate to 38 mEq/litre.

The patient continued to make steady progress; on the 25th post-operative day a further throat culture was sterile, but a rectal culture remained positive to *Staphylococcus aureus*, mildly resistant to chloramphenicol. The chloramphenicol was discontinued. Her bowels were completely controlled to one or two normal actions a day. She is now out of bed, enjoying a full gastric diet, with the wound securely healed, and the small pelvic mass has disappeared. I think that the successful outcome was due to massive venous fluid replacement, at the same time maintaining electrolyte balance. Cortisone enabled the patient to deal more adequately with the infection and to overcome the peripheral circulatory failure. Pamine may have helped in reducing the number of bowel actions. And the chloramphenicol controlled the fulminating organisms once the diagnosis had been made.

I thank Mr. Troup, under whose care this patient was admitted, for his permission to record these facts, and Dr. Brinton for his very helpful suggestions.—I am, etc.,

Alton, Hants. A. H. HAYSOM.

Ichthyosis and Hypnosis

SIR,—In August, 1952, I reported in your *Journal*[1] the case of a boy of 16 suffering from congenital ichthyosiform erythroderma of Brocq who was treated by hypnosis. The case was of exceptional interest, as no previous record of a congenital structural disease improving existed. That such a condition should improve by psychotherapeutic methods is even more inexplicable, and, to quote from a letter in your *Journal* by Dr. F. Ray Bettley,[2] "demands a revision of current concepts of the relation between mind and body." It will be recalled that the patient improved limb by limb in direct response to hypnotic suggestion, thus ruling out the possibility of spontaneous resolution.

It is now four years since this patient was first treated, and the present condition of the case is of great interest. If any alteration had occurred either for better or worse, and it were possible to relate this alteration to any environmental or psychological change, it might be possible to shed some light on the obscure aetiology of congenital illness. It was with the express purpose of observing this case further that members of the Dermatological Section of the Royal Society of Medicine asked me to re-present the

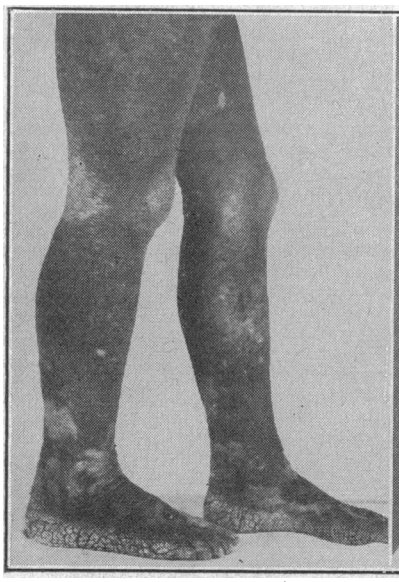

FIG. 1.—Before treatment.

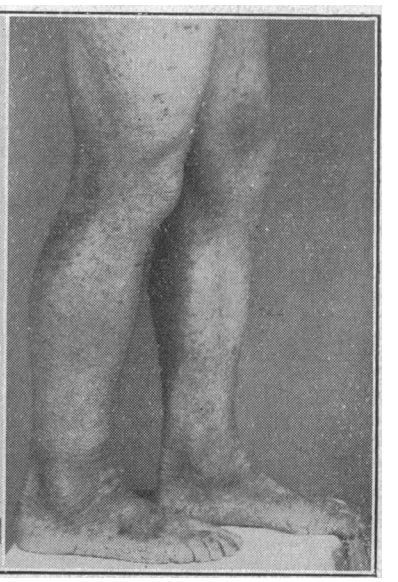

FIG. 2.—Four years after treatment.

patient. This was done on January 20, 1955, and I would like to record here the present condition of the patient.

He has of course physically matured greatly, as would be expected, and is now nearly 19 years old. He has also remained in work as an electrician's mate, and lately a bicycle mechanic, without a break since his discharge three years ago. Not only has there been no relapse, but his skin has continued to improve. What is also surprising is that this improvement should continue without further treatment of any sort, hypnotic or otherwise. The patient is in no doubt as to his improvement, and comparison of photographs confirms this. There is still considerable involvement of feet and some involvement of legs and thighs, but all much less severe. The arms and hands are quite clear, and abdomen, buttocks, and back are only slightly involved. Nowhere is there evidence of cracking and infection, which had been such a disabling and painful complication previously. The smell has also quite gone.

I attempted to hypnotize the patient again, and it is curious to relate that, while on discharge he had been a good hypnotic subject, he was now quite unhypnotizable. I tried again two weeks later and this time succeeded, but further suggestions made in the hypnotic state that his legs would improve did not prove efficacious.

One other fact I feel should be brought to notice is the case of pachyonychia congenita treated by Mullins *et al.*[3] by hypnosis. This is a congenital condition closely allied to Brocq's ichthyosis and with a very similar pathology. That this also responds favourably to hypnotic suggestion shows that the treatment is repeatable in other hands and that the improvement in the case I reported is not a freak occurrence.—I am, etc.,

A. A. MASON.

London, W.1.

REFERENCES

1 Mason, A A., *British Medical Journal*, 1952, **2**, 422.
2 Bettley, F. R., ibid., 1952, **2**, 996.
3 Mullins, J. F., *et al.*, *Arch. Derm. Syph. (Chicago)*, 1955, **71**, 265.

Book Reviews

SIR,—As part editor of two medical journals, I have always held the opinion that book reviews should be unsigned. I can think of no more convincing support of this opinion than the letter from Dr. Iago Galdston (*Journal*, June 11, p. 1430).

Professor McKeown (*Journal*, March 19, p. 710) was asked his opinion of a book dealing with a subject on which he is an authority. He read it. He did not think much of it. He said so—humorously, a little unkindly, but certainly not maliciously. Any author should expect some reviews of this sort and be prepared to take them. Any reviewer is entitled to write them, and should not, as the result, be subjected to outraged abuse.

It would have been more in accordance with the dignity of the *B.M.J.* had this exhibition of childish tantrums been forwarded without comment to the reviewer, and kept out of the correspondence columns.—I am, etc.,

HENEAGE OGILVIE.

London, N.W.8.

Bell's Palsy Treated With Vitamin B_1

SIR,—Over the last two years we have had three cases of Bell's palsy; they have all been treated with vitamin B_1 injections plus B_1 tablets, and the following results were obtained.

Case 1.—A woman, aged 28, attended the surgery complaining of watering of the right eye and inability to lower the lid, and also dribbling from the mouth. These symptoms had come on suddenly about 36 hours previously. On examination she had a complete, typical, right-sided Bell's palsy. She was injected with 50 mg. vitamin B_1 intramuscularly and given 50 mg. vitamin B_1 tablets three times a day for six days. When she attended daily for her injections the following improvements were noted: first day—able to close her eyelid slightly; second day—no epiphora; third day—could half-close eye, no dribbling from mouth; fourth day—mouth almost level and could puff out cheeks; fifth day—could easily close eye, mouth level on smiling, partial wrinkling of forehead; sixth day—no abnormal signs or symptoms. The patient was under treatment by a psychiatrist for anxiety neurosis. He had noticed the palsy and had referred her to a neurologist for treatment. That evening the patient attended surgery and the above-mentioned treatment was commenced. The appointment made by the psychiatrist for the patient to see the neurologist was booked for seven days later; she kept this appointment and the neurologist was unable to find any trace of palsy

Case 2.—A woman, aged 40, came complaining of pain below and behind the right ear, slight drooping of the mouth, and inability to close her eye fully. Bell's palsy was diagnosed and three intramuscular injections of vitamin B_1 50 mg. were given on three successive days, plus B_1 tablets 50 mg. Not only did the symptoms become no worse, but on the fourth day the patient was perfectly well.

Case 3.—A male, aged 50, whose symptoms had existed for a few days was given intramuscular injections of vitamin B_1 50 mg., plus B_1 tablets 50 mg. for six days, but it was about 14 days before recovery was complete.

It is stated[1] that with or without treatment it takes about three or four weeks before voluntary movement is possible in Bell's palsy, and some months before complete recovery. It appears to us that from these quick results following B_1 injections and oral treatment in, admittedly, a few cases the treatment is worthy of a more extensive trial.—We are, etc.,

R. G. WIGODER.
H. G. JEFFS.

London, S.E.6.

REFERENCE

1 Conybeare, J., in *Textbook of Medicine*, 1952, edited by J. Conybeare and W. W. Mann, 10th ed., p. 700. Livingstone, Edinburgh.

Opportunities for Medical Practice

SIR,—May I add a note to the article by Sir Stanley Davidson on opportunities for medical practice (*Journal*, May 14, p. 1171) with regard to the position in West African colonies? Private practice amongst Europeans is very limited in Nigeria owing to the relatively small white population, but all forms of hospital and private practice amongst the African population are at the present time in great need of increased staff.

While it is certainly the ideal that the medical needs of Nigeria should be in the hands of Nigerian doctors, it will still be many years before sufficient graduates from Ibadan University medical school are forthcoming, and the situation is in many areas quite desperate. Nigeria is heavily populated, yet there are large areas, measured in hundreds of miles, where there is no medical care, no hospital—government or mission—and only the poorest of supplies in village dispensaries staffed by overworked and often untrained nurses. There is at least one fully equipped newly built government hospital only 250 miles from Ibadan in an area greatly in need which has never even been opened because there is no doctor available.

While, therefore, the time will come when West Africa will, like the Dominions and some other colonies, become medically self-supporting, that time, as Sir Stanley points out, is still a long way off. Practitioners anxious to do a worth-while job in a growing country will find open arms in the towns and cities of Nigeria if not of the West African colonies as a whole.—I am, etc.,

R. SCHRAM.

Ibadan, Nigeria.

Tonsillectomy

SIR,—While having luncheon to-day at Great Ormond Street after my operating list I read the description of guillotine tonsillectomy and curettage of adenoids by Mr. J. C. Campbell and Dr. D. Hunter Smith (*Journal*, June 18, p. 1451). I had, during the morning, removed large lateral adenoid remnants causing deafness and repeated otitis media in four children. My experience is that if lateral adenoid tissue, around and below the Eustachian cushions, is not completely removed at the adenoid operation it subsequently hypertrophies and often causes more ear troubles than the patient had suffered before the operation. Campbell and Smith state that with a good ethyl chloride anaesthesia the surgeon can have up to two minutes to guillotine the tonsils and curette the adenoids. It takes me more than two minutes of deep anaesthesia to palpate the adenoids and assess their size and disposition, to remove the central mass by one stroke of the curette and the lateral extensions around the Eustachian cushions by a stroke on each side, and then to remove any small pieces that may have escaped these three strokes and are still palpable. This is the most